Medicare Advantage Medical Benefit Drug Policy

BlueCross BlueShield Nebraska

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Effective Date: 10/07/2021

Enzyme Replacement Therapy for Gaucher's Disease

Cerezyme® (imiglucerase)
Elelyso® (taliglucerase)
Vpriv® (velaglucerase alfa)

FDA approval: Various
HCPCS: J1786 – Cerezyme, J3060 – Elelyso, J3385 - Vpriv
Benefit: Medical

Policy:

Requests must be supported by submission of chart notes and patient specific documentation.

A. Coverage of the requested drug is provided when all the following are met:
   a. FDA approved indication
   b. FDA approved age
   c. Prescribed by or in consultation with a geneticist or metabolic specialist
   d. Confirmation of diagnosis by biochemical assay showing decreased glucocerebrosidase activity in white blood cells or skin fibroblasts AND genotyping revealing two pathogenic mutations of the glucocerebrosidase gene
   e. Two symptomatic manifestations of the disease are present, such as anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly
   f. Trial and failure, contraindication, OR intolerance to the preferred drugs as listed in the BCBSNE MA Part B drugs prior authorization list

B. Quantity Limitations, Authorization Period and Renewal Criteria
   a. Quantity Limits: Align with FDA recommended dosing
   b. Authorization Period: 1 year at a time
   c. Renewal Criteria: Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit

***Note: Coverage may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at http://www.cms.hhs.gov/. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

Therapeutic considerations:

A. **FDA approved indication / Diagnosis**

**Please refer to most recent prescribing information.*

B. **Background Information**

a. Gaucher's disease (GD) is autosomal recessive lysosomal storage disorder caused by a mutation on the gene glucocerebrosidase 1. It is characterized by lysosomal accumulation of undegraded glucosylceramide due to a deficiency or insufficient activity of the enzyme glucocerebrosidase. There are three main disease variants with type 1 being considered non-neuronopathic and the least severe. Signs, symptoms, and severity vary greatly among patients with type 1 GD. The most common symptoms include anemia, thrombocytopenia, bone disease, including bone abnormalities and osteopenia/osteoporosis, and hepatosplenomegaly.

b. The American College of Medical Genetics 2011 guidelines state Gaucher's disease is confirmed through identifying reduced glucocerebrosidase activity in peripheral leukocytes or skin fibroblasts and through genetic testing that shows the patient has two pathogenic mutations of the glucocerebrosidase gene.

c. Enzyme replacement is the standard of care in GD. Three enzyme replacement therapies are FDA approved for long-term enzyme replacement in type 1 Gaucher's disease: Cerezyme, Elelyso, and Vpriv. Elelyso and Vpriv are approved for patients age 4 years and older and Cerezyme for patients 2 years and older. Guidelines do not recommend the use of one enzyme replacement therapy over another.

d. Treatment should be initiated when two of the following symptoms are present: hepatomegaly, splenomegaly, interstitial lung disease, pulmonary hypertension, anemia, thrombocytopenia, bony pain crisis, osteopenia, aseptic necrosis of the femoral head, bony lytic lesions, bony infarctions, or pathologic fractures. Symptom improvement is typically seen within 1 year from the start of therapy for major peripheral symptoms. Bone abnormalities may take up to several years to respond to therapy.

e. Decisions regarding dose management should be made by physicians who are experienced in caring for patients with Gaucher's disease with the deciding factor for dosing being the achievement of therapeutic goals. Dose reductions can occur once significant improvements are achieved and maintained for at least a year. Patients with severe manifestations are not recommended to have dose reductions after initial improvement. Adult patients at increased risk who have achieved all therapeutic goals can have the dose decreased in small increments (approx. 15% - 20%) until their next scheduled evaluation in 3 - 6 months. These adult patients and all children are not recommended to have a long-term maintenance dose less than 30 U/kg every 2 weeks. Lower-risk adult patients may tolerate larger dose reductions of 25% - 50% per dose. The minimum long-term dose for lower-risk adults is recommended to be no less than 20 U/kg every 2 weeks.

C. **Efficacy**

**Please refer to most recent prescribing information.*

D. **Medication Safety Considerations**

**Please refer to most recent prescribing information.*

E. **Dosing and administration**

**Please refer to most recent prescribing information.*

F. **How supplied**

**Please refer to most recent prescribing information.*

References:

1. Cerezyme [prescribing information]. Cambridge, MA: Genzyme Corporation; April 2018.
2. Elelyso [prescribing information]. New York, NY: Pfizer, Inc.; July 2021.
3. Vpriv [prescribing information]. Lexington, MA: Shire Human Genetic Therapies, Inc.; December 2020.
4. Weinreb N et al. A benchmark analysis of the achievement of therapeutic goals for type 1 Gaucher disease patients treated with imiglucerase. Am J Hematol. 2008; 83(12): 890-95.
5. Gonzalez DE et al. Enzyme replacement therapy with velaglucerase alfa in Gaucher disease: Results from a randomized, double blind, multinational, Phase 3 study. Am J Hematol. 2013; 88(3): 166-71.
6. Weinreb NJ, Aggio MC, Andersson HC, et al. International Collaborative Gaucher Group (ICGG). Gaucher disease type 1: revised recommendations on evaluations and monitoring for adult patients. Semin Hematol. 2004; 41: 15 – 22.
7. Wang RW, Bodamer OA, Watson MS, et al. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. Genetic Med. 2011 May; 13 (3): 457 – 484.

Policy/UM Medical Management System Update History		
#	Date	Change Description
1.1	Effective Date: 10/07/2021	Annual review – no changes to the criteria at this time
1.0	Effective Date: 10/08/2020	New policy created for this disease state and class of drugs. The Enzyme Replacement Therapy policy will be retired

** The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or http://dailymed.nlm.nih.gov/dailymed/index.cfm.*